Application for License to Operate a Special Health Clinic or Health Service

FOR ADMINISTRATIVE USE ONLY

Date received _____
Amount received _____

I. IDENTIFICATION

Name _____

Address _____

City/County/Zip _____

Telephone number _____

Director _____

Date operation began at current address _____

Date operation began under current owner _____

II. CONTROL (check one in each column)

State	Profit	Individual
County	Nonprofit	Partnership
City		Corporation
Private		

Name and address of individual owner, partners or corporation

_____

_____

_____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Parent Corporation (If applicable)	Management Company (If applicable)
_____	_____
_____	_____

(OVER)

III. **TYPE SERVICE/CLINIC** (Check appropriate service or clinic)

Magnetic Resonance Imaging

Computed Tomography Scanning

Lithotriptor

Cardiac Catheterization

Radiation Therapy

X-Ray

Other Diagnostic Imaging Service

_____

Is service mobile? Yes ____ No ____

Family Planning Clinic

Pulmonary Care Clinic

Disability Determination Clinic

Weight Loss Clinic

Speech and Hearing Clinic

Wellness Center

Counseling Center

Other Diagnostic Center

_____

IV. **SERVICE AREA**

Area served (if applicable) _____

_____

_____

V. **OTHER LOCATIONS**

Address of other locations (if applicable) _____

_____

_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this service and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

_____ _____ _____

Signature of authorized representative Title Date

Return application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 142
(10/2002)